



## **Affidavit of Domestic Partnership Termination**

I \_\_\_\_\_ certify that I previously filed the appropriate Affidavit with  
Franklin County Employee Name (Print)

the Franklin County Benefits Office to establish a domestic partnership, and I now inform the County that

\_\_\_\_\_ is no longer my domestic partner as of  
Name of former Domestic Partner (Print)

\_\_\_\_\_  
Date

I understand that my former domestic partner is no longer eligible for benefits provided by Franklin County as of the date identified above as the date our domestic partnership ended.

I also certify that I will provide my former domestic partner with a copy of this Affidavit at the following address:

\_\_\_\_\_  
Name of former Domestic Partner (Print)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

**Note:** If applicable, Franklin County will use this address to mail Health Plan Continuation of Coverage information to your former domestic partner, unless another address is provided.

I understand that another Affidavit of Domestic Partnership to establish a new domestic partnership cannot be filed until six (6) months after this domestic partnership has been terminated. I understand this form may be supplied to my agency's Human Resources Department.

\_\_\_\_\_  
Signature of Employee Date of Birth Date

Employee's Social Security Number (required): \_\_\_\_\_ Agency: \_\_\_\_\_

\_\_\_\_\_  
Signature of Benefits Office Date

**Please return form(s) to:**  
Franklin County Benefits Office  
373 S. High Street, 25<sup>th</sup> Floor  
Columbus, Ohio 43215  
Phone: 614.525.5750  
Fax: 614.525.5515  
E-mail: [benefits@franklincountyohio.gov](mailto:benefits@franklincountyohio.gov)  
Website: <http://BeWell@FranklinCountyOhio.gov>